U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 22Oct2001

CASE NO.: 1999-BLA-672

In the Matter of:

VEON F. BAYS,
Claimant

v.

SEWELL COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Mary Rich Maloy, Esq.,
For the Claimant

Ray E. Ratliff, Jr., Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on June 17, 1998. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. I deny this claim because the miner has failed to establish a total respiratory disability due to a coal mine dust exposure related affliction. However, I have conducted a full-scale review of the record to ensure fairness to the miner.

PROCEDURAL HISTORY

The claimant filed his first prior claim for benefits on filed on February 24, 1971. (Director's Exhibit ("DX") 20). The claim was finally denied, on November 17, 1980, because the evidence failed to establish any of the elements of entitlement. (DX 20). His second claim, filed on August 6, 1984, was denied, on May 31, 1985, because the evidence failed to establish any of the elements of entitlement. (DX 21). His third claim, filed on November 16, 1994, was denied, on April 20, 1995, because the evidence failed to establish that Mr. Bays was totally disabled due to pneumoconiosis and he had not established a material change in conditions, under 20 C.F.R. § 725.309. (DX 22). His fourth claim, filed on June 11, 1996, was denied, on October 30, 1996, because the evidence failed to establish that Mr. Bays was totally disabled due to pneumoconiosis. (DX 23).

The claimant filed this fifth claim for benefits on June 17, 1998. (Director's Exhibit ("DX") 1). Benefits were initially awarded, on February 9, 1999. (DX 19). On January 11, 1999, a hearing before an administrative law judge was requested by the employer. (DX 18). On March 8, 1999, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX 24). I was assigned the case on July 11, 2001 after numerous continuances and cancelled hearings.

On August 28, 2001, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[2] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibit ("CX") 1, Director's exhibits ("DX") 1-24, and Employer's exhibits ("EX") 1-30 were admitted into the record.[3] It appears interim benefits were paid.

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[2] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[3] The claimant objected to the voluminous number of consultative reports submitted by the employer. (TR 21). While voluminous, the reports are not cumulative and were properly admitted.

ISSUES[4]

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner[5]

The parties agreed and I find claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least seventeen years. (Hearing Transcript (TR) 6; DX 1; DX 2).

[4] The employer withdrew controversion of several issues. (TR 6).

[5] Former subsection 718.301(a) provided that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. 20 C.F.R. § 718.301 now provides that it must be computed as provided by § 725.101(a)(32). The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 B.L.R. 1-67, 1-72 (1996)(en banc); *Dawson v. Old Ben Coal Co.*, 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP, 8 B.L.R. 1-430, 1-432 (1986); Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

B. Date of Filing[6]

The claimant filed his claim for benefits, under the Act, on June 17, 1998. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

The parties agreed and I find Sewell Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations.[7] (DX 2; DX 4).

D. Dependents

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Dellaphene. (DX 1).

E. Personal, Employment and Smoking History

The claimant was born on August 23, 1922. (DX 1). He married Dellaphene Bays on April 4, 1947. (DX 1). He worked in the coal mines for thirty-eight years. (DX 1; DX 2). He stopped coal mining on August 31, 1984. (TR ; DX 1). The mine was closing and he retired. The claimant's last position in the coal mines was that of a motor operator. (Hearing Transcript (TR) 9). The claimant, as part of his duties, was required to perform daily heavy lifting, i.e., roof bolts in bundles and thick cable. (TR 9-11). The claimant is not a cigarette smoker.

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[6] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).

> (a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner . . .
>
> (c) There shall be a rebuttable presumption that every claim for benefits is timely filed . . . the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

[7] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R.§ § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). The second presumption has been rebutted in this case.

II. Medical Evidence

A. Chest X-rays[8] and CT Scans[9]

There were eleven readings of three CT scans, taken between 05/15/98 and 04/16/99. (Appendix A). There were approximately ninety-five readings of twenty-four X-rays, taken between 1971 and 10/24/00. (Appendix A). The majority of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102 (b).[10] Thirty-three X-ray readings are positive by physicians who primarily are board-certified in radiology and/or B-readers.[11] The remainder (sixty-two) are negative by physicians who are primarily either B-readers, board-certified in radiology, or both. All but one of the CT scan readings are clearly negative.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

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[8] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed**.** 20 C.F.R. § 718.102(e)(Effective Jan. 19, 2001).

[9] *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). A CAT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an x-ray under § 718.304(a). A CAT Scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)."

[10] ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[11] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. §37.51. Courts generally give greater weight to x-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compre-hension Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Jacobson 08/07/80 DX 20, p. 33	57 65"	3.01	91	3.52	Yes		No*	Spagnolo finds normal. (EX 4). Morgan finds essentially normal with underestimated FVC. (EX 17).
Daniel 10/03/84 DX 21	62 66"	3.19	136	4.04	Yes	Good	No*	Spagnolo finds normal. (EX 4). Fino finds normal. (EX 5). Morgan finds normal for age. (EX 17).
Shank 01/04/95 DX 22	72 66"	2.16	59	3.08	Yes	Good	No* Yes**	Spagnolo finds normal with slightly reduced MVV related to effort. (EX 4). Fino finds normal with invalid MVV & no small airways disease. (EX 5; Dep. 18). Morgan finds no basis for find-ing minimal small air-ways disease. (EX 17).
Greenburg 07/09/96 DX 23	73 66"	2.34	58	3.30	Yes	Good	No* Yes**	Spagnolo finds normal with slightly reduced MVV related to effort. (EX 4). Fino finds normal with invalid MVV. (EX 5). Jarboe finds normal. (EX 8).
Durham 05/11/98 DX 14, p. 16	75 65"	1.64 1.76+	none 51.6+	2.50 2.48+			No* No*	Mild to moderate obstruction. Fino ques-tions validity since he had no tracings. (EX 5). Jarboe finds inaccur-ate reflection of func-tion, based on subse-quent PFS results. (EX 8).

Physician **Date** **Exh.#**	**Age** **Height**	FEV_1	MVV	FVC	Tra-cings	Compre-hension Cooper-ation	Qualify * Conf-orm**	Dr.'s Impression
Durham 07/08/98 DX 7	75 65"	2.10	64	3.01	Yes	Good Good	No* Yes**	Mild obstructive LD. Spagnolo finds normal with slightly reduced MVV related to effort. (EX 4). Fino finds normal. (EX 5).Morgan finds no obstructive LD & submaximal effort. (EX 17).
Castle 01/13/99 EX 1	76 65"	2.45 2.49+	108 107+	3.30 3.34+	Yes	Good Good	No* Yes** No* Yes**	Entirely normal PFS. Spagnolo finds normal. (EX 4). Fino finds normal.(EX 5). Morgan finds normal. (EX 17).
Ranavaya 10/24/00 CX 1	78 65"	1.86 1.74+	42.5 53.6+	2.86 2.91+	Yes	Fair Fair	No* No*	Drs. Renn, Spagnolo, Castle, & Morgan find invalid. Fino did not review this test. Dahhan finds no impairment. Morgan says it is with-in normal range. (EX 27). Renn finds FEV1 underestimated from poor effort and no satisfactory FVC & MVV maneuvers. (EX 30).

The heavy line denotes evidence considered in the prior claims.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

For a miner of the claimant's height of 65 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.48 for a male 78 years of age.[12] If such an FEV_1 is shown, there must be in addition, an

[12] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 65" here, the most often reported and most recent height.

FVC equal to or less than 1.92 or an MVV equal to or less than 59; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
65"	57	1.70		
66"	62	1.72		
66"	72	1.57		
66"	73	1.57		
65"	75	1.48		
65"	76	1.48		
65"	78	1.48	1.92	59

C. Arterial Blood Gas Studies[13]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**PCO_2**	**PO_2**	**Qualify**	**Physician Impression**
10/03/84 DX 21	Daniel	40 35+	82 99+	No No	Spagnolo finds normal. (EX 4). Morgan finds normal for age. (EX 17).
01/11/95 DX 22	Shank	39.9 37.9+	80.9 76.8+	No No	Spagnolo finds normal. (EX 4). Fino finds normal. (EX 5).
08/08/96 DX 23	Greenburg	38.9 40.5+	94.2 80.9+	No No	Spagnolo finds normal. (EX 4). Fino finds normal. (EX 5). Jarboe finds normal. (EX 8).

[13] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . . .
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

Date Ex.#	Physician	PCO_2	PO_2	Qualify	Physician Impression
07/14/98 DX 7	Durham	36.1 36.8+	76.6 75.7+	No No	Mild hypoxia on exercise. Fino finds normal. (EX 5).
01/13/99 EX 1	Castle	33.7 35.7+	83 74+	No No	Normal results. Fino finds normal. (EX 5). Morgan finds normal. (EX 17).
10/24/00 CX 1	Ranavaya				Unable to administer.

The heavy line denotes evidence considered in the prior claims.

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Durham, whose qualifications are not in the record, completed a DOL form, dated July 21, 1998, reporting the results of his examination. (DX 7). He did not note the years of coal mine employment or the nature of the claimant's work, but did record a non-smoking history. (DX 7). Based on non-qualifying arterial blood gases, a non-qualifying pulmonary function study showing a mild obstructive disorder, and a positive chest X-ray, Dr. Durham diagnosed: hypertension; CAD; and, CWP due to coal dust exposure. He opined that the miner was 20 percent disabled of which 90 percent was due to CWP. (DX 7).

Dr. Mohammed Ranavaya is a B-reader and is Board-certified in occupational medicine. (CX 1). His report, based upon his examination of the claimant and review of enumerated records, on October 24, 2000, notes 38.5years of coal mine employment and a non-smoking history. (CX 1). Although he mentioned the miner's jobs, he did not address job requirements. Based on examination, history, a "non-qualifying" pulmonary function study showing a mild obstructive ventilatory defect, and a positive chest X-ray, Dr. Ranavaya diagnosed CWP due to occupational coal mine dust exposure. He found radiological evidence of complicated CWP and mild pulmonary obstructive ventilatory insufficiency. (CX 1).

Dr. James R. Castle is a B-reader and is board-certified in internal medicine with a sub-specialty in pulmonary medicine. (EX 1). His detailed report, dated May 10, 1999, based upon his review of enumerated records and his examination of the claimant, on January 13, 1999, notes 38.5 years of coal mine employment and a non-smoking history. (EX 1). Dr. Castle described the claimant's work history and the nature of his work. Based on a normal examination, history, EKG with ST-T changes consistent with ischemia, "normal" and non-qualifying arterial blood gases, a non-qualifying pulmonary function study showing normal or very mild, clinically-insignificant airway obstruction, and positive chest X-ray, Dr. Castle diagnosed: simple CWP with no respiratory impairment; CAD; and post-CABG. While Mr. Bays may be disabled from a cardiac view due to CAD, Dr. Castle found he retained the respiratory capacity to perform his last coal mine duties. (EX 1).

The employer filed a supplemental report from Dr. Castle, dated September 16, 1999. (EX 13). He had thoroughly reviewed additional enumerated materials. He concluded Mr. Bays "most likely does not have coal worker's pneumoconiosis." It appears he was particularly influenced by Board-certified radiologist's, Dr. Wiot's deposition. Dr. Castle observed the rapid progression of the opacities between 9/28/93 and 7/8/98, the locations, CT scan appearance, findings of pleural effusions, and absence of apical disease, all makes it "extraordinarily unlikely that these changes are due to coal worker's pneumoconiosis." He says it is entirely possible Mr. Bays has sarcoidosis or pleural effusions related to heart disease.[14] While he remains disabled by CAD, he has no respiratory impairment. Even if he suffered from CWP, he would not have a respiratory impairment. (EX 13).

Dr. Castle testified at a deposition, March 20, 2000. (EX 24). He reiterated his credentials, testified about his experience, including special expertise in CWP-related matters, and the substance of his earlier reports. Additionally, he had reviewed more enumerated materials. (Dep. 10-11). He added the miner had informed him of his heavy labor. (Dep. 12). He reiterated Mr. Bays has no obstructive or restrictive lung disease. (Dep. 15). He has normal lung function and suffers no respiratory impairment. (Dep. 15). However, he may be disabled from CAD. He reiterated that the 3 cm mass seen in the 5/15/98 CT scan was not there on the 7/27/98 scan so it was a transient inflammatory process, not a category A opacity due to CWP or cancer. (Dep. 21). Dr. Castle explained how he could mark the ILO X-ray form as "3/2" profusion, yet not now believe a CWP process is involved. (Dep. 23). Moreover, initially he lacked the benefit of seeing a series of X-rays and the CTs. (Dep. 24). He concludes the miner has neither simple nor complicated CWP and no respiratory impairment. (Dep. 25).

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[14] Sarcoidosis is "a chronic, progressive, systemic granulomatous reticulosis of unknown etiology, involving almost any organ or tissue, including the skin, lungs, lymph nodes, liver, spleen, eyes, and small bones of the hands and feet. It is characterized histologically by the presence in all affected organs or tissues of noncaseating epitheloid cells tubercles. . .Called also Besnier-Boeck or Boeck's disease, sarcoid, sarcoid of Boeck, and Schaumann's disease, sarcoid, or syndrome." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Ed. (1994) at 1485. "Reticulosis " is "an abnormal increase in cells derived from or related to reticuloendothelial cells. Cf. leukemia and lymphoma." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Ed. (1994) at 1453.

The employer filed yet another supplemental report from Dr. Castle, dated February 8, 2001, wherein he reviewed additional enumerated materials. (EX 27). Nothing in the additional materials changes his opinion. Dr. Ranavaya's complicated CWP diagnosis was based upon an invalid PFS. His other PFSs had been normal. The timing of the development of the lesions shown on X-ray is inconsistent with CWP. Moreover, the CT scan results do not show CWP. (EX 27).

Dr. Samuel V. Spagnolo who is Board-certified in internal medicine with a sub-specialty in pulmonary diseases, submitted a comprehensive report, dated June 12, 1999, reviewing enumerated records. (EX 4). He noted 38 years of coal mine employment, involving heavy labor, and a non-smoking history. He concluded the miner did not suffer from CWP, nor is there evidence of any restrictive or obstructive impairment which rules out emphysema or interstitial fibrosis. Admittedly, he relies on the X-ray interpretations of Drs. Wheeler, Wiot, W. Scott, and Siegelman, because they are university-based and their reports not finding CWP are uniformly consistent. Moreover, their interpretations, i.e., granulomatous disease, fit more closely with the other clinical findings. (EX 4). The miner is not unable to perform his last coal mining job.[15] Even if he were found to have CWP, he would not be disabled by it. (EX 4).

A supplementary report from Dr. Spagnolo, dated January 21, 2000, was submitted by the employer. (EX 18). He had reviewed enumerated documents not available at the time of his earlier review. He found Dr. Jarboe's 7/12/99 opinion incomplete as he had not consider sarcoidosis, a common granulomatous pulmonary condition frequently unaccompanied by respiratory symptoms, which could explain Mr. Bays' X-ray changes. Dr. Spagnolo reiterated his belief, based on the normal PFSs, lung pathology report, multiple negative physical examinations, and the pattern of X-ray results from 1973-1999, that the miner does not suffer from CWP, but rather has sarcoidosis. He is most influenced by the X-ray readings which prefer a granulomatous lung change diagnosis, which fits more closely with the miner's clinical course and objective findings. He points out the CT scan is more accurate than X-ray. Finally, he concludes Mr. Bays does not have a respiratory impairment attributable to CWP or a pneumoconiosis. Even if he had CWP, he would remain unimpaired.

The employer submitted a second supplemental report, dated February 8, 2001, by Dr. Spagnolo, wherein he reviewed additional enumerated materials. (EX 27). He reconfirmed his opinion that Mr. Bays does not suffer from CWP and has no respiratory impairment attributable to a pneumoconiosis. Even if he had CWP, it would not change Dr. Spagnolo's determination he was unimpaired. He calls Dr. Ranavaya's interpretation "incomplete, superficial, and misleading!" The 2/24/00 biopsy sample was diagnostically inadequate. Dr. Ranavaya's PFS was invalid due to poor effort. (EX 27).

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[15] "Granuloma" is an imprecise term applied to (1) any small nodular delimited aggregation of mononuclear inflammatory cells, or (2) such a collection of modified macrophages resembling epithelial cells usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Granuloma formation usually represents a chronic inflammatory response initiated by various infectious and noninfectious agents. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Edition (1994), p. 716.

Dr. Gregory Fino, who is Board-certified in internal medicine with a sub-specialty in pulmonary diseases, and is a B-reader, reviewed the claimant's medical records on behalf of the employer and submitted his opinions in a comprehensive report, dated June 16, 1999. (EX 5). His consultation report notes 38.5 years of coal mine employment and a non-smoking history. Although he noted the miner's work included loading supplies, he did not discuss the degree of labor involved other than assuming it was heavy labor. Dr. Fino concluded that the claimant did not have pneumoconiosis, based on the majority of negative X-ray readings and his negative readings and that the miner was not disabled due to any pulmonary impairment. (EX 5). The significant increase in the number of pulmonary nodules over a very short time period is inconsistent with CWP. However, even if he suffered from CWP, he would remain unimpaired. (EX 5).

A supplementary report from Dr. Fino, dated January 26, 2000, was submitted by the employer. (EX 19). He had reviewed enumerated documents not available at the time of his earlier review. Dr. Fino's earlier opinion remained unchanged.

Dr. Fino testified at a deposition, March 27, 2000. (EX 25). He reiterated his credentials, testified about his experience, including special expertise in CWP-related matters, and the substance of his earlier reports. He observed that a nodule or mass he had seen on the earlier CT scan had resolved in two months, the location of the nodules (sparing the upper zones), and the rapid changes in the size and presence of nodules noted on X-ray rule out CWP. (Dep. 10). The pattern here is "pretty classic for sarcoidosis." (Dep. 11, 24). No one knows what causes sarcoidosis, a lung disease, but it is not coal mine dust inhalation. (Dep. 11). Mr. Bays' medical history fits together well for CAD. (Dep. 15). Essentially, all his AGS and PFS were normal and he could perform any type of manual labor. (Dep. 19-20, 25).

The employer submitted yet another report from Dr. Fino, dated February 7, 2001, wherein he reviewed additional enumerated materials. (EX 27). He stipulated that if the biopsy report of 2/24/00 finding simple CWP was correct, he would conform his diagnosis to it. However, other than Dr. Ranavaya's complicated CWP diagnosis, he finds no evidence to support such a finding. Reading the same X-ray, he would not diagnose complicated CWP. (EX 27).

Dr. Raphael Caffrey, who is Board-certified in anatomic and clinical pathology, reviewed enumerated medical records of the claimant and a histologic slide on behalf of the employer and submitted his opinions in a report, dated June 24, 1999. (EX 6). His consultation report notes 38.5 years of coal mine employment and a non-smoking history. He observed the slide showed a mild amount of anthracotic pigment, but no nodules, granulomas or macules and showed no malignancy. The biopsy itself is inadequate to determine whether or not the miner has an occupational lung disease.[16] While the miner does not suffer from complicated CWP, he could not determine whether or not Mr. Bays had CWP, but if he did it would be simple CWP. If he has simple CWP, he agrees it is not disabling.

[16] Dr. Morgan agrees that whatever is present could not be determined without adequate biopsies. (EX 17, p. 11).

Dr. John M. Daniel, who is Board-certified in family practice, reviewed unidentified medical records of the claimant, between the early 1980's and June 1984, on behalf of the employer and submitted his opinions in a report, dated July 6, 1999. (EX 7). His consultation report notes 38.5 years of coal mine employment and a non-smoking history. He had examined the miner on October 3, 1984. Reviewing X-ray readings, he opined "in all probability did have a very slight or mild case of simple pneumoconiosis." Based on normal AGS and PFS, he believes the miner has no respiratory impairment of any type. He is disabled from a cardiac viewpoint. Even if CWP was confirmed, he would not be impaired by it.

Dr. A. Dahhan, who is Board-certified in internal medicine with a sub-specialty in pulmonary medicine, reviewed enumerated medical records of the claimant on behalf of the employer and submitted his opinions in a report, dated July 9, 1999. (EX 7). His consultation report notes 38.5 years of coal mine employment and a non-smoking history. He did not discuss the labor demands of the miner's work. Dr. Dahhan concluded Mr. Bays has radiological findings suggestive of simple CWP, but no complicated CWP. He retains the respiratory capacity to return to his previous coal mine work as demonstrated by the lack of any impairment in lung function. His CWP has not caused any apparent alteration in lung function. (EX 7).

The employer submitted a supplemental report by Dr. Dahhan, dated January 4, 2000. (EX 16). He reviewed additional enumerated materials. He believes there are sufficient radiological findings to diagnose simple CWP, but not complicated CWP. Nor does the tissue diagnosis indicate complicated CWP. Despite the CWP, Mr. Bays retains the respiratory capacity to perform his previous coal mine work or comparable work. He has CAD. (EX 16).

The employer submitted a second supplemental report by Dr. Dahhan, dated February 2, 2001, wherein he reviewed additional enumerated materials. (EX 27). Dr. Dahhan persisted in his opinion the miner has simple CWP, but not complicated CWP, based on X-ray, AGS, PFS, and the results of examinations. While the miner has CAD, he has no respiratory impairment. (EX 27).

Dr. Thomas M. Jarboe, who is a B-reader and Board-certified in internal medicine with a sub-specialty in pulmonary diseases, reviewed enumerated medical records of the claimant on behalf of the employer and submitted his opinions in a report, dated July 12, 1999. (EX 8). His consultation report notes 38.5 years of coal mine employment and a non-smoking history. While noting the miner's job title, he did not discuss the degree of its labor demands. Dr. Jarboe believes there was sufficient objective information to justify a CWP diagnosis. He observed a CWP diagnosis, however, best explains clear evidence of the diffuse nodular changes, which cannot be due to metastatic disease since the miner would now be dead if that was true.[17] Moreover, it is unlikely they are granulomas because they would not appear in the chest and increase in size and number over time as here without clear evidence of respiratory illness. Dr. Jarboe does not believe the miner has a significant respiratory or

[17] Dr. Morgan disagrees, stating it could be metastatic disease. (EX 17, p. 11).

pulmonary impairment, as nearly every PFS has been normal. The variable AGS-exercise response, i.e., on 1/13/99, is abnormal, but within normal limits. Mr. Bay's CAD and significant HBP would be disabling. (EX 8).

The employer submitted a supplemental report by Dr. Jarboe, dated February 1, 2000. (EX 21). He had reviewed additional enumerated materials. He reiterated his belief the miner has CWP, based primarily on the nodular densities atypically found in the X-ray evidence in his mid and lower lung zones. There does not appear to be evidence he has any other disease. However, the PFSs and AGSs show he has no respiratory disability. Mr. Bays has CAD and significant HBP which could be disabling in a man his age. (EX 21).

Dr. Jerome F. Wiot testified at a deposition, on July 12, 1999. (EX 9). He reiterated his very impressive credentials, which included participation in the development of the ILO CWP X-ray standards and CWP pathology standards, and his interpretations of CT scans and X-rays in this case. He testified a radiologist who reads a series of X-rays to reach the best diagnosis. (Dep. 16). He described what a radiologist looks for and the comparisons made with ILO standards in diagnosing both CWP and complicated CWP. He explained the difference between regular X-rays and CT scans. (Dep. 22-24). He found no evidence of pleural plaques, complicated CWP, or CWP in the X-rays or CT scans he reviewed, but Mr. Bays did have other abnormalities, i.e., pleural disease and mediastinal lymph nodes (which could be but probably are not sarcoidosis) unrelated to coal dust exposure. (Dep. 24-28). The reader who found complicated CWP was wrong and may have mistaken a 3 cm mass which subsequently disappeared for it. (Dep. 28). He concluded saying while he did not know what Mr. Bays has, but it is not CWP. (Dep. 30).

The employer submitted the report of Dr. W.K.C. Morgan, dated January 17, 2000, with attached CV. (EX 17). Among other qualifications, he is a B-reader. Dr. Morgan thoroughly reviewed and commented on enumerated records. He noted 38.5 years of coal mine employment and a non-smoking history. He assumed Mr. Bays was not exposed to high quantities of dust. (EX 17, pp. 11 & 13). The opacities in the X-rays he reviewed are not compatible with either CWP or silicosis. "After his retirement he had no further exposure to coal or silica and thus the two diseases can be excluded." The three CT scans show calcified opacities which are probably granulomata. It is possible he has metastases or some slow-growing tumor. He concluded Mr. Bays does not have CWP. Dr. Morgan states:

> Now that the dust levels are significantly reduced there is compelling evidence to show that simple CWP does not develop in those persons who started working after 1970. Moreover, Mr. Bays' jobs in the coal mine were not that dusty. . . Since the miner's disease progressed rapidly from 1993 where there was any to category 2, and in some person's estimates category 3, over the space of three to four years. This is completely impossible taking into account that he was no longer exposed to coal dust and that simple CWP does not progress after exposure has ceased.

(EX 17, p.13-14). Dr. Morgan says there is no question Mr. Bays developed rapidly progressing nodular disease and some parenchymal changes with pleural effusions between 1993 and 1999. The calcifications of the nodules suggests some granulomatous condition; CWP never calcifies and silicotic nodules uncommonly calcify. Since he had no silicosis upon leaving coal mining it can be excluded. Histoplasmosis, metastatic disease, rare calcification of the nodules, and cardiac disease, i.e., mitral stenosis, are conditions which could cause his nodules.[18] Moreover, the miner's herpes zoster can lead to pinpoint calcifications, which is unlikely here. "The only way to know for certain what is causing his condition is to do a needle biopsy or open lung biopsy." Mr. Bays' PFS do not reflect abnormal lung conditions. His effort during PFS was often submaximal. Whatever caused his nodules "is certainly not causing any respiratory impairment." (EX 17, p. 14).

The employer submitted a supplemental report, dated February 5, 2001, by Dr. Morgan, wherein he reviewed additional enumerated records. (EX 27). He persisted in his opinion that Mr. Bays could not have been exposed to much coal dust. His "0/0" and "0/1" X-rays in 1973 and negative reading in 1980 held significance, showing he had no CWP when he left coal mining. Dr. Morgan is "unimpressed" by Dr. Ranavaya's observations and believes he misinterpreted the biopsy results. He adheres to his earlier opinion that the miner has no CWP or respiratory impairment. He is disabled by his age alone in addition to CAD. (EX 27).

The employer submitted a report, dated January 18, 2001, by Dr. Richard Naeye in which he reviewed enumerated records and a histologic slide. (EX 26). Dr. Naeye is Board-certified in clinical and anatomic pathology and is extensively published. He noted the miner's 38.5 years of coal mine employment and non-smoking history. He noted the miner's jobs, but not the degree of labor required. The slide material was insufficient to determine whether or not the miner had CWP. However, the sample did not show the findings of CWP. He opined the lesions some X-ray readers thought to be CWP were not because they became apparent post-mining, simple CWP does not advance post-mining, they were not in the upper lobes typical of CWP, and none of the PFS demonstrate CWP abnormalities. If he has simple CWP, it would be so mild it could not cause any abnormalities in lung function or disability. (EX 26).

The employer submitted a pulmonary pathology consultation report, dated March 6, 2001, by Dr. Erika Crouch. (EX 28). Professor Crouch is Board-certified in anatomic pathology, is very well published, has widely lectured, and has served as a consultant to OWCP. She examined two histologic slides and noted that transbronchial biopsies provide too limited of a sampling for a reliable assessment of CWP and neither rule out or establish the existence of the disease. The slides showed coal dust deposition with no coal dust architectural changes. Given the conflicting X-ray interpretations and the right upper lobe mass which regressed which most likely was a granulomatous or inflammatory process, she found no objective evidence of any clinically evident respiratory impairment due to

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[18] "Histoplasmosis" is "infection resulting from inhalation or, infrequently, the ingestion of spores of Histoplasma capsulatum. . . in 1-5 percent, it causes acute pneumonia, or disseminated reticuloendothelial hyperplasia with hepatosplenomegaly and anemia, or an influence-like illness with joint effusion and erythema nodosum. Reactivated infection , such as in immunocompromised patients, involves the lungs, meninges, heart peritoneum, and adrenals in that order of frequency. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Edition (1994), p. 770.

occupational coal dust exposure. (EX 28). She found herself in "essential agreement" with Drs. Naeye, Caffrey, and Morgan.

III. Hospital Records & Physician Office Notes

The employer submitted 62-pages of miscellaneous medical records.[19] (DX 14). Dr. Richard Durham's clinic notes refer to the miner's history of CWP, CAD, HTN, PUD, hyperlipidemia, significant dyspnea, and a 3 cm RUL lung mass, suggested on pathology (bronchoscopy) to be a hamartoma or bronchogenic carcinoma.[20] Dr. Durham opined, in mid-1998, the miner was developing PMF secondary to CWP. Based on a 6/9/95 X-ray showing some interstitial lung process and his examination, in June 1995, Dr. Cox diagnosed "dyspnea of undetermined etiology in an individual with presumed coal worker's pneumoconiosis." He added however, the dyspnea may be due to his interstitial lung disease or beta blockers he took. Dr. Stanton treated the miner for severe triple-vessel CAD, hypertension, and hyperlipidemia in May 1993. He noted a remote chewing tobacco history. Cardiac catheterization was done, by Dr. Stanton, followed by CABG in May 1993 by Dr. Malik. Several post-CABG follow-ups are in the exhibit.

IV. Biopsy Evidence

The record contains the results of a lung biopsy performed on May 22, 1998. (DX 14). The tissue was obtained from the right upper lung. Microscopic examination, by Dr. Manuel Gomez, revealed the stroma was diffusely infiltrated by lymphocytes and histocytes. There was also an irregular fragment of hyaline cartilaginous tissue. The final diagnosis was: negative for malignancy; and, special stains for acid-fast microorganisms and fungi negative; hyaline cartilaginous tissue (hamartoma?).

A second biopsy report (2/24/00) is referenced in Dr. Ranavaya's October 30, 2000 report. (CX 1). It was a pathology report by Dr. Gomex of a left lung lower lobe specimen. It revealed fibrosis with atelectasis, chronic inflammation and deposition of coal pigment. Dr. Ranavaya reported Dr. Gomez stated the findings were consistent with fibrosis with atelectasis, pneumoconiosis-coal worker's type. (CX 2, pp. 6-7).

V. Witness' Testimony

Mr. Bays testified he had breathing problems when he retired in 1984. He would get out of breath climbing stairs. (TR 13). In May 1993, he had a CABG after which his breathing was "fair." (TR 15). But, he would still be out of breath stair climbing and could only walk 50-100 feet. He is a non-smoker. (TR 15). Today, his breathing has worsened. (TR 16). He could not return to his last coal mining job because of breathing problems. (TR 19-20).

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[19] This exhibit contained many duplicates of existing evidence and was apparently not reviewed by its submitter.

[20] Dr. Morgan reported a hamartoma would be "remarkable" in this case. (EX 17).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205*; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp*., 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP, v. Mangifest*, 826 F.2d 1318, 1320 (3d Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Since this is the claimant's fifth claim for benefits, he must initially show that there has been a material change of conditions.[21]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial, i.e., disability due to the disease.[22] *Lisa Lee Mines v. Director, OWCP [Rutter],* 86 F.3d 1358 (4th Cir. 1996) (*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den*. 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3d Cir. 1995).[23] *See Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to

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[21] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

[22] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition, under 20 C.F.R. § 725.309, absent corroborating medical evidence.

[23] *Allen v. Mead Corp*., 22 B.L.R. 1-61 (2000). In Circuits which have not addressed the standard applicable to duplicate claims, under 20 C.F.R. 725.309, the Board overruled its position, in *Shupink v. LTV Steel Co.*, 17 B.L.R. 1-24 (1992), and adopts the position articulated in *Peabody Coal Co. v. Spese*, 117 F.3d 1001 (7th Cir. 1997)(*en banc*). That is, to establish a material change in conditions, a claimant must establish with evidence developed subsequent to the denial of the earlier claim that at least one of the elements of entitlement previously adjudicated against him or her.

determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F. 3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc*., 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)*(en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that the miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions. . ."

The claimant's prior application for benefits was denied because the evidence failed to show that the claimant was totally disabled by pneumoconiosis. Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.[24] *Sharondale*.

In this matter, I find, as explained in detail below, that the miner has failed to establish a material change in condition. There is no evidence establishing he suffers from a total respiratory disability let alone one due to coal mine dust exposure. Moreover, the CT scan, X-ray evidence, and physician opinion evidence does not establish the existence of the disease. The facts establish Drs. Ranavaya and Navani were wrong in their diagnoses of complicated CWP.

B. Existence of Pneumoconiosis

For purposes of this decision, I need not and do not finally decide the matter of the existence of CWP because the basis for the denial is the lack of proof of disability. Nonetheless, I can make certain limited findings and discuss other aspects related to the issue. Pneumoconiosis is defined as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[25] 30 U.S.C. § 902(b) and 20 C.F.R. §718.201. The definition is not confined

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[24] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition under 20 C.F.R. § 725.309, absent corroborating medical evidence.

[25] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11,

to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[26]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[27] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic

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1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[26] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[27] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases . . . attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See*, e.g., *Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106;[28] (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[29] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The record contains biopsy evidence. See § 718.202(a)(2). In the opinions of the employer's experts, i.e. pathologists, Drs. Naeye and Crouch, the biopsy sample here (2/24/00) was inadequate to either find or rule out CWP.[30] Moreover, the earlier pathology report concerning a lung tissue sample (5/22/98) did not diagnose CWP, but rather a hamartoma or bronchogenic carcinoma. Dr. Caffrey found that sample inadequate for diagnostic purposes. Unfortunately, the second biopsy report (2/24/00), conceivably the most important evidence in the claimant's behalf, was not itself submitted as evidence. I am unable to ascertain its compliance with the regulations.

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[28] A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis, but positive results will constitute evidence of the presence of pneumoconiosis 20 C.F.R. § 718.106(c).

[29] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[30] The only biopsy report of record substantially compies with the requirements set forth in § 718.106(a), in that (it) includes a detailed gross macroscopic and microscopic description of the visualized portion of the lung and a copy of the surgical notes and pathological report of the examination of the specimen. *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1540 (11th Cir. 1993); *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988).

The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after Jan. 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.[31] 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP.[32] "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31, 1-37 (1991). Here, sixty-two readings of twenty-four X-rays taken between 1971 and 10/24/00 were negative for CWP versus only thirty-three positive readings. The Board has made it clear that physician comments can be considered in ascertaining the etiology of pneumoconiosis.[33]

I observe some of the B-readers, such as Drs. Fino, W. Scott, Meyer, and Wheeler, attributed their readings to sarcoidosis, histoplasmosis, tuberculosis, granulomata, or cancer (metastatic disease). Dr. W.K.C. Morgan stated that whatever the miner has could not be determined without adequate biopsies. Pulmonologist-B reader, Dr. Fino, diagnosed a classic case of sarcoidosis as did pulmonologist Dr. Spagnolo. Dually-qualified radiologist Dr. Meyer considered sarcoidosis. However, the employer's best-qualified radiologist, Dr. Wiot, ruled out sarcoidosis. Only four readers, Drs. W. Scott, Wheeler, Kim, and W.K.C. Morgan, of the thirty-five reading the X-rays over a period of thirty some years consistently found histoplasmosis. Likewise, three of those four, W. Scott, Wheeler, and Kim, and Dr. Meyer (dually-qualified radiologist) out of a total of thirty-five readers, also found

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[31] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. . . *See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W. VA. LAW REVIEW 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

[32] See Footnote 4.

[33] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's x-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on x-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

granulomatous disease. Dr. Wiot, the employer's best-qualified radiologist found neither histoplasmosis or granulomatous disease. Drs. W. Scott, Wheeler and Meyer account for twenty of the sixty-two negative X-ray readings, almost one-third. If Dr. Wiot's ten negative readings (all his reads were negative) were included, nearly a full half of the negative readings are attributable to only five readers of thirty-five. Ninety percent of Dr. Wheeler's readings were negative while only 60 percent of Dr. W. Scott's were and at least Dr. Meyer found possible CWP in four of his nine readings. Drs. W. Scott, Wheeler, and Meyer, did not read and there is no evidence they were aware of any of the many positive readings between 1971 and his first reading of the 9/28/93 X-ray. Nor was there evidence Dr. Spitz was familiar with the readings between 1971 and his first reading on 2/10/97. At least twenty-two different readers examined X-rays dated January 4, 1995 or later. Some of those readers were also not familiar with the miner's radiological history. Dr. Castle made six readings through January 1999 finding all the X-rays positive. A reading of the 2000 X-ray by Dr. Castle was not submitted. In September 1999, after reviewing Dr. Wiot's deposition, Dr. Castle reversed his CWP diagnosis and diagnosed either sarcoidosis or pleural effusions related to heart disease. The 2000 positive biopsy came after Dr. Castle's change of diagnosis. In the end, Dr. Wiot admitted he did not know what the miner's lung disease was, but that it was not CWP.

I recognize that despite the existence of ILO standards that subjective differences of opinion exist between X-ray readers. In fact, one of the employer's experts pointed out how one reader was a "liberal" one and he gave those readings less credence whereas he gave Dr. Wiot's readings more credence because of his qualifications. Moreover, one view holds reading X-rays to diagnose CWP is at best an imprecise art.[34]

The four CT scans, of 1998 and 1999, appear to be negative for CWP. Only Drs. Rose and Durham, whose qualifications are unknown, reported the 5/15/98 CT scan had a nodular interstitial pattern "possibly" consistent with CWP. CTs are much more accurate than X-rays.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently

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[34] "Because the lung is limited in the way it responds to various insults, the differentiation between CWP, silicosis, and other interstitial nodular disease by the roentgenogram alone is not possible in most cases." *"Pathology Standards for Coal Worker's Pneumoconiosis,"* Report of the Pneumoconiosis Committee of the College of American Pathologists to the National Institute for Occupational Safety and Health, at 383.

reasoned if the underlying objective medical data contradicts it.[35] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank pulmonologists, Drs. Dahhan, Jarboe, Castle, Spagnolo, and Fino equally. I rank pathologists Drs. Naeye, Crouch, and Caffrey equally. I find the dually-qualified readers rank equally with slightly more credit to Dr. Wiot because of his background. I rank Drs. Ranavaya and Daniel equally. I give Dr. Ranavaya as much credence as I do the pulmonary specialists. I give Dr. Daniel somewhat less credence than either the pulmonary specialists, the pathologists or Board-certified radiologist when it comes to evidence in their respective fields. I note that these general rankings are based solely upon their credentials of record and do not imply that I either credit or discount their opinions on any specific particular matter.

There is a distinction between a physician who merely examines a miner and one who is one of his "treating" physicians.[36] Dr. Durham was Mr. Bays treating physician for several years. As such, generally his opinion would ordinarily be entitled to more weight as he is more likely to be familiar with the miner's condition than a physician who examines him episodically.[37] *Onderko v. Director, OWCP*,

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[35] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp*., 6 B.L.R. 1-1291 (1984). . ."

In *Cornett v. Benham Coal, Inc*., 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the Court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

[36] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994).

[37] § 718.104(d) Treating physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the

14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors).[38] However, any additional credit which might be accorded to Dr. Durham, as a treating physician, is counterbalanced by the lack of any record qualifications or specialized expertise.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).[39] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). The rule in the Fourth Circuit is set forth in *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

Here, Drs. Durham, Ranavaya, Daniel, Dahhan and Jarboe all diagnosed CWP. Drs. Castle, Spagnolo, Fino, Caffrey, Wiot, W.K.C. Morgan, Naeye, and Crouch all found no CWP. Dr. Durham did not have the most recent X-rays and CT scans in reaching his July 1998 CWP diagnosis and the record lacks his qualifications. Dr. Daniel relied primarily on X-ray readings to find CWP. Dr. Dahhan found radiological findings suggestive of CWP. Dr. Jarboe likewise relied primarily on X-ray evidence,

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miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

[38] *See, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.2d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989).

[39] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993) and *Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135 (1987).

although the X-ray he relied on to find CWP did not show typical CWP opacities. Drs. Daniel, Durham, and Dahhan lack radiological credentials. Most of the positive X-ray readings the physicians finding CWP relied on were either contradicted by other better qualified readers or explained not to be CWP. Among other matters, Dr. Ranavaya relied on X-ray readings which showing a category "B" opacity, which no one else observed and related to a mass which had apparently resolved. Dr. Navani's reading of the 7/8/98 X-ray is far outweighed by readings of numerous readers who had more information.

Dr. Castle read six X-rays through 1999 positive for CWP. Then in 1999, after reviewing Dr. Wiot's deposition, he changed his CWP diagnosis to exclude CWP and find sarcoidosis or pleural effusions from heart disease. Dr. Wiot had concluded however, that the process was not sarcoidosis. Dr. Castle was not aware of the positive 2000 biopsy. Dr. Fino conceded that if the 2000 biopsy was correct, the miner had CWP. Dr. Spagnolo found the 2000 biopsy inadequate, along with Drs. Naeye and Crouch. Neither Dr. Wiot nor Dr. W.K.C. Morgan actually could say what the miner's lung disease was. Dr. Wiot concluded it was not CWP, but he did not have the 2000 biopsy results. While Dr. Morgan had the 1998 biopsy results, which he felt were inadequate, he apparently did not have the results of the 2000 biopsy.

Dr. Ranavaya was wrong in his complicated CWP diagnosis. The mass he had observed on X-ray to make that diagnosis later disappeared and was not a pneumoconiotic nodule. Further, the PFS he relied on was invalid. The best most recent evidence here is the most recent CT scan and possibly the 2000 biopsy. The 1998 biopsy did not reveal CWP, although it was arguably inadequate for such a diagnosis. Finally, while the non-qualifying" AGS and PFS results may ordinarily not be used in the determination of the existence of the disease, they suggest the miner lacks a respiratory impairment, in that they had "normal" results.

If the claimant files yet another claim, these are all matters which must be addressed.

C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, I am not deciding this issue.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[40] Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[41] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Here, not only are all the PFS "non-qualifying" they were read as "normal" for the miner's age. Thus, the PFS do not establish total disability.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). Here, not only are all the AGSs "non-qualifying" they were read as "normal" for the miner's age. Thus, the AGSs do not establish total disability.

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[40] § 718.204 (Effective Jan. 19, 2000). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[41] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to walk distances or climb without shortness of breath, I find he is incapable of performing his prior coal mine employment.[42]

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP,[Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.'" Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id*. at 534. The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).

None of the physicians of the more than one dozen physicians whose opinions I have reviewed has found the claimant disabled by a respiratory affliction. Coupled with the non-qualifying PFS and AGS, the claimant has failed completely to prove total respiratory disability. This failure is the primary basis for denying his claim.

[42] Judges may rely on physician reports which do not discuss the exertional requirements of a miner's work if the physician concludes that the miner suffers from no impairment at all. *Lane v. Union Carbide & Director, OWCP*, 21 B.L.R. 2-34, 2-46, 105 F.3d 166, 172 (4th Cir. 1997).

I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[43]

The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).[44]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[45] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245. The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

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[43] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___ , BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[44] Effective January 19, 2001, § 718.204(a) states, in pertinent part:
For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[45] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, *914 F.2d 35* (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[46]

The evidence in this case does not establish any total respiratory disability. Nor is the claimant's impairment caused by any coal mine dust inhalation or related affliction. However, it is shown that he is impaired by coronary artery disease and his advanced age.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in conditions has taken place since the previous denial. I do not decide the existence or possible cause of pneumoconiosis, as defined by the Act and Regulations. The claimant has not established that he is totally disabled or that his impairment is due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER[47]

It is ordered that the claim of Veon F. Bays for benefits under the Black Lung Benefits Act is hereby DENIED.

A
RICHARD A. MORGAN
Administrative Law Judge

RAM:dmr

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[46] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claims . . . in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

[47] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001).

Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**.[48] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[48] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001).

(d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

APPENDIX A

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 20	3/23/71 4/12/71	T. Martin	Radiol-ogist		1, p	CWP.
DX 20, p. 43	7/25/73 7/26/73	Fischer			1/1, s	
DX 20	9/27/73	Illegible			1/0, p, 6 LZ	
DX 20, p. 48	9/27/73 9/27/73	I.D. Scott			0/1, p	
DX 20, p. 47	9/27/73 11/29/73	Furnary		yes	0/1, 0/0, p, 3 LZ	Em.
DX 20, p. 46	9/27/73 12/16/73	Siegelman		yes	0/0	Negative.
DX 20, p. 37	08/07/80 11/04/80	R.H. Morgan	B	1	0/0	Negative.
DX 20	08/07/80	Abdala	BCR	1	q, 2 LZ	
DX 21	10/03/84 10/03/84	Daniel		plus	0/0	Negative.
DX 21	10/03/84 10/20/84	Gaziano	B	1		Negative.
DX 14	5/9/93 5/10/93	Conner	MD			Nodular interstitial LD question etiology.
DX 14	5/10/93 5/10/93	Conner	MD			Nodular increased interstitial bilateral markings. LL linear atelectasis.
DX 14	5/11/93 5/11/93	REC				Subsegmental atelectasis changes LL base.
DX 14, p. 51	5/12/93 5/12/93	R. Smith				Mild left perihilar atelectasis. Lung fields clear.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 14, p. 47	5/13/93 5/13/93	Conner				Small pleural effusion. Mildly prominent interstitial markings bilaterally consistent w chronic LD.
DX 14	5/15/93 5/16/93	JAW				Small bilateral pleural effusions. Diffuse pulmonary fibrosis with interstitial nodules.
DX 14	9/28/93 9/28/93	Logan				Small left pleural effusion. No acute disease. Small chronic nodular interstitial densities possibly secondary to CWP. No active parenchymal or mediastinal LD.
DX 15	9/28/93 12/02/98	W. Scott	B; BCR	1		Negative. CABG. Histoplasmosis. Granulomata. Some associated pleural disease.
DX 15	9/28/93 12/03/98	Wheeler	B; BCR	1		Negative for CWP or silicosis..
DX 16	9/28/93 12/29/98	Wiot	B; BCR[49]			Negative.
EX 2	9/28/93 5/13/99	Fino	B	1	0/0	Negative.
EX 11	9/28/93 6/29/99	Pendergrass	B; BCR	1-2	0/1, r/q, 4 LZ	
EX 12	9/28/93 7/19/99	Meyer	B; BCR	1		Diffuse bilateral nodular disease with axillary coalescence atypical of CWP, but may be simple CWP. No large opacities. Consider granulomatous disease, sarcoidosis, metastases.

[49] The B-reader certificate enclosed with Dr. Wiot's CV expired 6/30/99.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 13, 24	9/28/93 9/15/99	Castle	B	2	½, r/q, 6 LZ	In 2001, Dr. Castle changed his opinion.
EX 17	9/28/93 1/5/00	Morgan	B	2	½, q/r, 6 LZ	
DX 14, p. 29	4/5/94 4/5/94	N. Hickey				Interstitial fibrosis undetermined etiology. CABG. No acute disease.
EX 15	4/05/94 12/02/98	W. Scott	B; BCR	1		Negative. CABG. Granulomata. Healed histoplasmosis.
EX 15	4/05/94 12/03/98	Wheeler	B; BCR	1		Negative. Ef. Possible granulomatous disease and histoplasmosis.
DX 16	4/05/94 12/29/98	Wiot	B; BCR	2		Negative.
EX 2	4/05/94 5/13/99	Fino	B	1	0/0	Negative.
EX 11	4/05/94 6/29/99	Pendergrass	B; BCR	not noted	½, r/q, 4 LZ	
EX 12	4/05/94 7/19/99	Meyer	B; BCR	1		Diffuse bilateral nodular disease with axillary coalescence atypical of CWP, but may be simple CWP. No large opacities. Consider granulomatous disease, sarcoidosis, metastases.
EX 13, 24	4/05/94 9/15/99	Castle	B	2	½, r/q, 4 LZ	In 2001, Dr. Castle changed his opinion.
EX 17	4/05/94 1/15/00	Morgan	B			Very similar to X-ray of 9/28/93. Atypical of CWP.
DX 22	01/04/95 01/04/95	Shah	B; BCR	1	2/2, q/p, 6 LZ	
DX 22	1/04/95 3/13/95	Gaziano	B	1	2/3, r/r, 6 LZ	

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 14, p. 26	06/09/95 06/09/95	Maki		DO		Significant underlying LD w/fibronodular pattern. Consistent w occupational exposure/CWP.
EX 15	06/09/95 12/04/99	Wheeler	B; BCR	1	0/1, q/q, 4 LZ	Some small nodules in central lung could be CWP, but recommend CT scan.
EX 15	06/09/95 12/04/99	W. Scott	B; BCR	1	1/1, q/r, 4 LZ	Small CWP component cannot be excluded-most likely granulomatous infectious process.
EX 15	06/09/95 12/16/99	Kim	B; BCR	1	0/1, q/q, 4 LZ	Nodular densities probably granulomatous process, but CWP cannot be excluded-most
EX 20	06/09/95 01/13/00	Wiot	B; BCR	1 & 2		Negative. Ca.
EX 22	06/09/95 02/06/00	Spitz	B; BCR	2		Negative. Ca.
EX 23	06/09/95 02/22/00	Meyer	B; BCR	1		Negative. Ca.
DX 23	07/09/96 07/09/96	Cook	B; BCR	1	2/2, q/q, 6 LZ	Dr. Cook omitted the date of the X-ray.
DX 23	07/09/96 09/08/96	Gaziano	B	2		Negative.
DX 23	07/09/96 09/25/96	Ranavaya	B	1	2/3, r/r, B, 6 LZ	
DX 23	07/09/96 10/22/96	Francke	B; BCR	1	2/2, r/q	
DX 14, p. 24	10/01/96 10/01/96	Maki	DO			S/P; CABG; degenerative change. Extensive underlying LD with reticular-fibronodular pattern. Probable EM change.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 14, p. 23	02/10/97 02/10/97	Maki				Extensive chronic underlying changes with fibronodular patterns. Extensive interstitial LD.
EX 15	02/10/97 12/04/99	Wheeler	B; BCR	1	0/1, q/q, 4 LZ	Some small nodules in central lung could be CWP, but recommend CT scan.
EX 15	02/10/97 12/04/99	W. Scott	B; BCR	1	½, r/r, 4 LZ	Most likely to or histoplasmosis. Calcified Granuloma.
EX 15	02/10/97 12/16/99	Kim	B; BCR	1	0/1, q/r, 4 LZ	Likely inflammation or granulomatous process.
EX 20	02/10/97 01/13/00	Wiot	B; BCR	2		Negative. Ca.
EX 22	02/10/97 02/06/00	Spitz	B; BCR	2		Negative. Ca.
EX 23	02/10/97 02/22/00	Meyer	B; BCR	2		Negative. Ca.
DX 14, p. 21	05/08/98 05/15/98	Bayfield				Interval increase in severity of nodular interstitial LD. **Prior LL lobectomy.** RUL patchy infiltrate possibly focal pneumonic process.
EX 15	05/08/98 12/04/99	Wheeler	B; BCR	1	0/1, q/q, 4 LZ	Some small nodules in central lung could be CWP, but recommend CT scan.
EX 15	05/08/98 12/04/99	W. Scott	B; BCR	1	0/1, q/q, 4 LZ	Granuloma compatible w tb or histoplasmosis. Cannot r/o tiny CWP component.
EX 15	05/08/98 12/16/99	Kim	B; BCR	1	0/1, q/r, 4 LZ	Granuloma compatible w tb or histoplasmosis. Cannot r/o CWP.
EX 20	05/08/98 01/13/00	Wiot	B; BCR	3		Negative. Ca.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 22	05/08/98 02/06/00	Spitz	B; BCR	2		Negative. Ca.
EX 23	05/08/98 02/22/00	Meyer	B; BCR	1		Negative. Ca.
DX 14 **CT**	05/15/98 05/22/98	Rose/Durham				3 cm oval mass w/i posterior RUL consistent with bronchogenic carcinoma. Reticular nodular interstitial pattern possibly consistent with CWP.
DX 16 **CT**	05/15/98 12/29/98	Wiot	B; BCR			No CWP. Extensive metastatic disease. Not characteristic of CWP due to sparing of upper lung fields.
EX 8 **CT**	05/15/98 07/12/99	Fino	B			No coal mine dust occupational LD.
EX 17 **CT**	05/15/98 05/15/99	Morgan	B			No CWP or silicosis.
DX 14, p. 19	05/22/98 05/22/98	Durham				No evidence of pneumothorax. Worsening bilateral non-specific nodularity.
DX 15	05/22/98 12/02/98	W. Scott	B; BCR	2		Negative. Increased bilateral infiltrates or edema or fibrosis. Consider tb. Probable granulomata & healed histoplasmosis.
DX 15	05/22/98 12/03/98	Wheeler	B; BCR	3		Negative. Ca; tb. Histoplasmosis. Granulomatous disease.
DX 16	05/22/98 12/29/98	Wiot	B; BCR	u/r		
EX 2	05/22/98 05/13/99	Fino	B	3	0/0	Negative.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 11	05/22/98 06/29/99	Pendergrass	B; BCR	1-2	2/1, r/r, 4 LZ	
EX 12	05/22/98 07/19/99	Meyer	B; BCR	2		Diffuse bilateral nodular disease with axillary coalescence atypical of CWP, but may be simple CWP. No large opacities. Consider granulomatous disease, sarcoidosis, metastases.
EX 13, 24	05/22/98 09/15/99	Castle	B	3	2/3, r/q, 5 LZ	In 2001, Dr. Castle changed his opinion.
EX 17	05/22/98 01/15/00	Morgan	B			Nodular densities. Increased opacification.
DX 7	07/08/98 07/08/98	Cruz	BCR	1	2/3, r/r, 6 LZ	CABG
DX 7	07/08/98 09/04/98	Navani	B; BCR	1	½, Cat. A, r/r, 6 LZ	CABG
EX 1, 13	07/08/98 05/07/99	Castle	B	1	3/2, r/q, 6 LZ	Castle later testified this was not CWP.
EX 10	07/08/98 07/21/99	Wheeler	B; BCR	2		Negative. Moderate nodular infiltrates compatible with tb or histoplasmosis.
EX 10	07/08/98 07/19/99	W. Scott	B; BCR	1	3/2, r/q, 6 LZ	Changes could be granulomatous LD or Metastases.
EX 11	07/08/98 08/04/99	Kim	B; BCR	2	2/3, r/q, 6 LZ	Granulomatous process suggested.
EX 13	07/08/98 09/15/99	Castle	B	1	3/2, r/r, 6 LZ	He read this film on 5/7/99 finding 3/2, r/q, 6 LZ
EX 17	07/08/98 01/15/00	Morgan	B			Some opacities almost 1 cm. with coalescence.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DE 14, p. 17, **CT**	07/27/98 07/27/98	Durham				3 cm mass RUL disappeared (Must have been inflammation). Pleural plaque or nodule remains. Diffuse nodular disease.
DX 15 CT	07/27/98 12/03/98	Wheeler	B; BCR			Granulomatous disease of possible metastases in lung & small bilateral effusions.
DX 15 CT	07/27/98 12/09/98	W. Scott	B; BCR			CABG. Infiltrates compatible with granulomatous disease or metastases. Bilateral pleural effusions w unusual intralung fluid collection on left which moves with change in position.
DX 16 CT	07/27/98 12/29/98	Wiot	B; BCR			No evidence of CWP. Extensive metastatic disease. Not characteristic of CWP due to sparing of upper lung fields.
EX 8 CT	07/27/98 07/12/99	Fino	B			No coal mine dust occupational disease.
EX 17 CT	07/27/98 01/15/00	Morgan	B			No CWP or silicosis.
EX 1	01/13/99 05/07/99	Castle	B	2	3/2, r/q, 6 LZ	Dr. Castle later testified this is not CWP. (EX 24 at 22-23).
EX 3	01/13/99 05/20/99	W. Scott	B; BCR	2	1/1, r/r, 6 LZ	ef; tb. Peripheral nodular infiltrates compatible w TB. Cannot r/o CWP or silicosis.
EX 3	01/13/99 05/21/99	Wheeler	B; BCR	3	0/1, q/q, 6 LZ	od; tb. Moderate small nodular infiltrates mixed with calcified granulomata compatible with histo-plasmosis more likely than TB.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 3	01/13/99 06/03/99	Kim	B; BCR	2	1/1, r/r, 6 LZ	Od; tb. Diffuse nodular infiltrates compatible w granuloma, but cannot r/o CWP or silicosis.
EX 9, 10	01/13/99 07/07/99	Wiot	B; BCR	1		Negative. Ca. Unquestionably metastatic disease.
EX 10	01/13/99 07/13/99	Perme	B; BCR	2	2/2, r/r, 6 LZ	O; ax; Od.
EX 12	01/13/99 07/19/99	Meyer	B; BCR	2		Diffuse bilateral nodular disease with axillary coalescence atypical of CWP, but may be simple CWP. No large opacities. Consider granulomatous disease, sarcoidosis, metastases.
EX 17	01/13/99 01/15/00	Morgan	B	2	2/2, r/q, 6 LZ	Many nodules approaching 1 cm, but not "large." Shape & distribution incompatible with CWP. Could be silicosis.
EX 14 **CT**	01/29/99 11/13/99	Wheeler	B; BCR	Good		Nodules not CWP because they are peri-pheral, asymmetrical & involve pleura.. Compat-ible with active granulo-matous LD, probably tb or Histoplasmosis. Cannot r/o metastases.
EX 14 **CT**	01/29/99 11/16/99	W. Scott	B; BCR			Nodules not CWP or silicosis. Cardiomegaly. Possible histoplasmosis, tb, fungal infection & neoplastic process.
EX 17 **CT**	01/29/99 01/15/00	Morgan	B			No CWP or silicosis.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 14 **CT**	04/16/99 11/13/99	Wheeler	B; BCR	Good		Active granulomatous LD increasing in RL. Compat-ible with active granulo-matous LD, probably tb or histoplasmosis with former more likely.
EX 14 **CT**	04/16/99 11/16/99	W. Scott	B; BCR			Nodules may be slightly increasing since prior CT.
EX 17 **CT**	04/16/99 01/15/00	Morgan	B			No CWP or silicosis.
EX 15	08/23/99 12/04/99	Wheeler	B; BCR	1	0/1, q/q, 4 LZ	Od. Some nodules could be CWP, but distribution pattern not consistent.
EX 15	08/23/99 12/04/99	W. Scott	B; BCR	2	0/1, q/q, 4 LZ	Od. Peripheral nodular infiltrates compatible w TB. Cannot r/o small CWP or silicosis component.
EX 15	08/23/99 12/16/99	Kim	B; BCR	2	0/1, q/r, 4 LZ	Od. Granuloma compatible w tb or histoplasmosis. Cannot r/o CWP.
EX 20	08/23/99 01/13/00	Wiot	B; BCR	2		Negative. Ca
EX 22	08/23/99 02/06/00	Spitz	B; BCR	1		Negative. Ca
EX 23	08/23/99 02/22/00	Meyer	B; BCR	1		Negative. Ca. X-rays 6/95-8/99 show indolent metastatic process. Chronic granulomatous infection less likely.
CX 1	10/24/00 10/24/00	Ranavaya	B	1	2/3, r/r, Cat. B, 6 LZ	Conglomerate lesions bilaterally likely PMF, but further study recom-mended to r/o malignancy.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 27	10/24/00 02/03/01	Wheeler	B; BCR	2	1/0, q/q, 6 LZ	Od; tb. Some small nodules in central lung could be CWP but it rarely involves all LZ. More likely histoplas-mosis.
EX 27	10/24/00 02/02/01	W. Scott	B; BCR	2	2/3, r/u, 6 LZ	Od; ca?; ef; tb. Could be tb or metastases.
EX 27	10/24/00 02/13/01	Kim	B; BCR	2	2/3; r/r, 6 LZ	Od; tb. Compatible w granulomatous process. Cannot exclude metastases.
EX 28	10/24/00 03/01/01	Wiot	B; BCR			Negative; Od. Multiple metastatic lesions. Pleural disease is not due to coal dust.
EX 28	10/24/00 03/03/01	Spitz	B; BCR			Negative; Od. Metastatic disease.
EX 29	10/24/00 03/16/01	Meyer	B; BCR	1		Negative; Od; Ca. Distribution & rapid changes of nodules inconsistent with CWP.

The heavy line after the last reading of the 7/9/96 X-ray denotes evidence considered in the prior claims.

* A- A-reader; B- B-reader; BCR- board-certified radiologist; BCP-board-certified pulmonologist; BCI= board-certified internal medicine; BCI(P)= board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))*(en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.